City Of Albuquerque
Medical/Occupational History
Return completed form to
Employee Health Center
Located on the Basement Level of Old City Hall
400 Marquette NW
768-4630

This physical exam is intended to verify your physical capability to perform the job for which you are being hired. It is not intended to take the place of exams given by your personal physician.

Name:_____Date:_____
(Last) (First) (Initial)

Social Security Number:_____ Date of Birth:_____

Reason for exam: Post-offer □ Annual □ Other□

Who is currently your Primary Care Physician? Name:_____

Please Check any of these items to which you have had exposures or needed medical treatment:

□ Asbestos □ PCB, PBB □ Vapors/Gases □ Other
□ Blood/Body fluids □ Metals (fumes/dusts) □ Vibration
□ Dusts □ Noise □ Heat/Cold Exposure
□ Radiation □ Carcinogens □ Pesticides

If ***YES*** to any of the above, describe below including a complete description of the exposure, dates of occurrences and name of physician who treated you. Also list place of employment, if exposure occurred in a work environment.

_____

_____

_____

1. Have you ever been injured on the job in any way?.....□ Yes □ No
2. Have you ever gotten sick in any way from something you worked with on the job?. .....□Yes □ No
3. Has your work ever caused problems with your joints(Wrists, etc.), your back or skin?.....□ Yes □ No
4. Have you had any hobbies or jobs in which you use chemical, metals, loud machines or tools, firearms, music amplifiers or other hazardous substance?.....□ Yes □ No
5. Have you ever claimed Worker's Compensation Benefits? If ***YES,*** explain below.....□ Yes □ No

_____

_____

_____

6. Have you ever had to terminate any job for health reasons?.....□Yes □ No
7. Have you ever had to transfer from one job to another or change job duties for health reasons? □Yes □No
8. Have you ever been refused any job for Health reasons?.....□ Yes □ No
9. Has a doctor ever placed restrictions on the kind of work you should do?.....□ Yes □ No
10. Has a doctor ever placed restrictions on your lifting, bending, twisting, walking, standing, sitting or using Your hands, arms or back?.....□ Yes □ No
11. Have you ever had a back injury or experienced back pain or back strain?.....□ Yes □ No
12. Have you ever filed a lawsuit for any injury?.....□ Yes □ No

ALLERGIES

List any allergies you have to drugs, foods, pollen, etc.

_____

_____

_____

REVIEW OF SYSTEMS

1. □ Yes □ No — Problem with overall fitness and feeling of well-being?
□ Unexplained fever □ Unexplained weight loss/ gain □ Unusual sweating □ Weakness □ Fatigue

2. □ Yes □ No — Problems with skin?
□ Recurrent or persistent rash □ Unexplained itching □ Eczema
□ Allergic skin rash □ Acne □ Psoriasis □ Dry cracked skin
□ Yellow color

3. □ Yes □ No — Problem with Blood or Bleeding?
□ Anemia (Low blood count) □ Nose Bleeds □ Bruising
□ Bleeding trait

4. □ Yes □ No — Problems with Diabetes?

5. □ Yes □ No — Problem with Muscles, Joints, Back?
□ Painful, stiff or swollen joints □ Arthritis □ Gout
□ Back Pain □ Back injury □ Sciatica □ Sore Muscles

6. □ Yes □ No — Problem with Eyes or Vision?
□ Wear Glasses/Contacts □ Loss of vision □ Lazy eye
□ Glaucoma □ Cataracts □ Yellow eyes

7. □ Yes □ No — Problem with Ears or Hearing?
□ Ringing or buzzing in the ears □ Loss of hearing □ Ear infection

8. □ Yes □ No — Nose and throat Problems?
□ Sinus trouble □ Hay Fever □ Recurrent sore Throats

9. □ Yes □ No — Breathing or Lung Problems?
□ Shortness of Breath □ Persistent Cough □ Bronchitis □ Tuberculosis
□ Coughing up blood □ Coughing up sputum □ Wheezing (Asthma)

10. □ Yes □ No — Problem with the Heart or Blood Vessels?
□ Rheumatic Fever □ Heart Murmur □ Palpitations □ Chest pain
□ Phlebitis □ Heart attacks □ Angina □ Heart failure
□ Varicose veins □ Unusually rapid heart beat

11. □ Yes	□ No	High blood pressure?
12. □ Yes	□ No	Problem with Stomach, Liver, or Bowels? □ Stomach/Abdominal pain/discomfort □ Stomach Ulcer □ Blood in stool □ Cirrhosis □ Recent change in bowel habits □ Hepatitis □ Heartburn □ Gallbladder Trouble □ Persistent diarrhea □ Hernia □ Yellow Jaundice
13. □ Yes	□ No	Problem with Bladder or Kidneys? □ Urine infection □ Frequent Urination □ Kidney stones □ Painful Urination □ Blood in the Urine □ Difficulty Urinating □ Kidney Failure
14. □ Yes	□ No	***(Men)*** Problem with the Male Organs? □ Infertility (Inability to have children) □ Trouble with sexual Performance □ Prostate infections □ Prostate enlargement □ Lump on Testicle
15. □ Yes	□ No	***(Women)*** Problem with Female Organs? □ Infertility (Inability to have children) □ Pelvic infections □ Painful Periods □ Missed, Irregular, Prolonged periods □ Breast Lumps or Discharge
16. □ Yes	□ No	***(Women)*** Are you Pregnant now?
17. □ Yes	□ No	Problems with the Nervous system? □ Seizures or convulsions □ Headaches □ Fainting or blackouts □ Numbness or Loss of Sensation □ Weakness of Arm or Leg □ Stroke
18. □ Yes	□ No	Emotional or Mental Problems? □ Depression □ Anxiety □ Nervous Breakdown
19. □ Yes	□ No	Any other Problems with pain? □ Pain/Discomfort in the chest □ Pain in the Arms, Wrists, Legs, or Back
20. □ Yes	□ No	Any Swelling in the Legs?

HEALTH MAINTENANCE RECORD

Are you now under the care of a physician for a health condition?..... □ Yes □ No

If ***YES***, what is the condition(s)?_____

_____

_____

When did you last have any of the following?

	Date	***Where***	***Results*** *(if Applicable)*
Physical Exam	_____	_____	_____
Eye Exam	_____	_____	_____
Chest X-ray	_____	_____	_____
Back X-ray	_____	_____	_____
Other X-ray/MRI	_____	_____	_____
Tetanus shot	_____	_____	_____
Tb Test	_____	_____	_____
Hepatitis vaccine	_____	_____	_____

Have you ever received instruction in back care and lifting techniques?.....□ Yes □ No

Females: Pap Smear	_____	_____	_____
Breast exam	_____	_____	_____

Have you ever been instructed in breast self-examination?.....□ Yes □ No

PAST MEDICAL HISTORY

Have you ever been Hospitalized?	□ Yes	□ No
Do you have any physical impairments?	□ Yes	□ No
Were you born with any physical defect?	□ Yes	□ No
Have you ever had surgery?	□ Yes	□ No
Have you ever broken a bone?	□ Yes	□ No

If **YES**, to any of the above, list the specific details including dates and names of treating physician.

_____

_____

_____

_____

FAMILY HISTORY

Have any of your parents, Brothers and/or Sisters ever had?
□ High Blood pressure □ Heart problems □ Stroke □ Diabetes

□ Cancer □ Bleeding disorder □ Mental disorder
□ Alcoholism

MEDICATIONS

List any Medicines including over the counter medicine you are taking?

_____

_____

_____

21. History of any kind of cancer?	□ Yes	□ No
22. Persistently swollen Lymph Glands?	□ Yes	□ No
23. Problem with Thyroid Gland?	□ Yes	□ No
24. Any other Health problems?	□ Yes	□ No

Use this space to explain any problem or to complete other sections as needed.

_____

_____

_____

_____

I certify the information contained in this record is correct and complete to the best of my knowledge and belief. I understand that knowingly making **a false statement** in this record shall be deemed sufficient cause for **rejection of my application** or **dismissal after employment.** I understand I shall be entitled to **no future worker's compensation** benefits if I knowingly and **Willfully conceal** or make **false representation** about the information requested. I understand that the City Of Albuquerque will rely on this Medical and Occupational History.

I AUTHORIZE THE CITY OF ALBUQUERQUE, NOW AND IN THE FUTURE, TO OBTAIN ANY MEDICAL RECORDS WHICH ARE REASONABLY RELATED TO MY ABILITY TO DO MY JOB.

To ensure compliance with Right to Privacy Laws, this form must be Sealed in the envelope provided and hand delivered to the Employee Health Center on the day of your physical, and/or drug test. If Pre-employment requirements do not include a physical and/or drug test this form must be hand delivered to the Employee Health Center prior to your first day of work.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

_____ _____

(Signature of Applicant) **(Date)**